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ABSTRACT

Grief is a natural response to loss. Bereavement is a universal biopsychosocial phenomenon, yet each individual has unique ways of expressing their loss. This recognition raises the question as to when the range of symptoms are typical and require no therapeutic intervention and when psychotherapeutic intervention is indicated. At present no criteria based definition of complicated bereavement exists. This limits access to services, presents risks of misdiagnosis, and/or inappropriate treatment. This review of the literature provides definitions of uncomplicated and complicated bereavement; and explores commonly used diagnostic categories related to complications in bereavement. Differing perspectives regarding the tendency to utilize the diagnosis of Major Depressive Disorder (MDD) are highlighted. A separate diagnostic category for complicated bereavement is recommended. Contains 30 references. (JBJ)

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# Complicated Bereavement:
# Definitions, Diagnosis, and Implications

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## Abstract

Bereavement is a universal phenomenon. At present no criteria based definition of complicated bereavement exists. This limits access to services, presents risks of misdiagnosis, and/or inappropriate treatment. This review of the literature provides definitions of uncomplicated and complicated bereavement; and explores commonly used diagnostic categories related to complications in bereavement. Differing perspectives regarding the tendency to utilize the diagnosis of Major Depressive Disorder (MDD) are highlighted. A separate diagnostic category for complicated bereavement is recommended.

# Complicated Bereavement:
# Definitions, Diagnosis, and Implications

Grief is a natural response to loss. When someone dies a person is affected and lives can be altered in significant ways. The process of bereavement is a universal biopsychosocial phenomenon (Widdison & Salisbury, 1990), yet each individual has unique ways of expressing their loss. This recognition raises the question when the range of symptoms are typical and require no therapeutic intervention and when psychotherapeutic intervention is indicated.

Freud's (1957) "Mourning and Melancholia" explored the topic of pathological grief. Freud viewed mourning as a normal response to loss and stated that it never requires medical intervention. Melancholia, what we now refer to as depression, was considered the outcome of unresolved grief. According to Freud, the distinguishing characteristic between these two presentations is that in melancholia a person's self-regard is negative. The similarities and differences between bereavement and depression remain to be clarified.

Lindemann (1944) identified typical physical and psychological symptoms in those experiencing grief related to the death of loved ones' from natural causes, disaster, and the military service. His study included presentation of normal and atypical grief-related reactions. His work indicated that one outcome of a complicated grief reaction is depression, however a broader spectrum of atypical responses was also described.

Numerous researchers since have attempted to distinguish when the bereavement process is normal and when it is pathogenic (Clayton, Desmarais, & Winokur 1968; Parkes, 1986; Robinson & Fleming, 1989; Zisook & DeVaul, 1983). Clayton et al. (1968) focused on defining normal grief. Predictive studies exist, which seek to determine who is at most risk to develop complications from bereavement (Clayton, 1990; Zisook & Shuchter, 1991). More specific studies have reviewed the outcome of bereavement to loss from murder (Rynearson, 1984) and following stillbirth (Condon, 1986). Extensive focus has been dedicated to the overlap between depression and bereavement (e.g., Clayton et al., 1968; Kim & Jacobs, 1991; Prigerson et al., 1995; Robinson & Fleming, 1989). Literature focusing on grief resolution also can assist the practitioner (e.g., Burnell & Burnell, 1989; Raphael, 1983).

Despite the range and intensity of the research in this field several practical issues have yet to be resolved: diagnostic criteria for complicated bereavement does not exist (Kim & Jacobs, 1991); there is the potential of overusage of the diagnosis of depression in the absence of such a specific diagnostic criteria (Robinson & Fleming, 1989); confusion relative to the delineation between bereavement-related depression and depression (Robinson & Fleming, 1989); differing perspectives regarding the treatment of bereavement-related depression (Clayton, 1990; Robinson & Fleming, 1989); and limited work has been done exploring a range of existing diagnostic categories (Prigerson et al., 1995).

The primary intent of this paper is to provide a review of the literature assimilating previous work regarding bereavement and complicated bereavement, and to explore diagnoses most commonly associated with complicated bereavement. Five diagnoses will be discussed: Uncomplicated Bereavement, Major Depressive Disorder (MDD), Adjustment Disorder, Generalized Anxiety Disorder, and Post-Traumatic Stress Disorder (PTSD). Discussion will focus on diagnosis, treatment, and the development of a separate diagnositic category relative to bereavement.

## Review of the Literature

### Definitions

Uncomplicated grief. Uncomplicated grief is considered to be a syndrome with psychological and somatic symptoms (Lindemann, 1944), which is self-limited (Kim & Jacobs, 1991), and begins in response to the death of a significant other (Robinson & Fleming, 1989). Worden (1982) identifies the following feelings as natural to grief: sadness, anger, guilt and self-reproach, anxiety, loneliness, fatigue, helplessness, shock, yearning, emancipation, relief, and numbness. Typical cognitions include: disbelief, confusion, preoccupation, sense of presence of the deceased, and hallucination (Worden, 1982). The American Psychiatric Association's (APA) (1994) Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) identified common somatic symptoms: "insomnia, poor appetite, and weight loss" (p. 684). Other somatic complaints include: respiratory disturbances, fatigue, and digestive problems, (Lindemann, 1944). Behavioral

manifestations are: restlessness, searching, crying, avoidance or seeking out of reminders of the deceased, social distancing (Worden, 1982), and disturbance of normal routine (Lindemann, 1944).

The process of bereavement has overlapping stages (Parkes, 1986). Typically the intitial response to the presentation that the loved one has died is numbness (Parkes, 1986), also termed denial and shock (Zisook & DeVaul, 1983). This is a relatively brief stage (Zisook & DeVaul, 1983). Next, pining and yearning for the deceased are evident (Parkes, 1986). Disorganization and despair then dominate (Parkes, 1986). It is during this stage in which depressive symptoms may develop (Clayton, 1990). These feelings tend to peak between one to two years following the death and then gradually dissipate (Zisook, DeVaul, & Click, 1982). The final phase is recovery (Parkes, 1986), marked by reorganization and adaptation (Burnell & Burnell, 1989). In recognition to the lost roles relative to the deceased, a somewhat new identity is formed (Parkes, 1986). There is acceptance of the death and functioning returns to what it was prior to this loss (Clayton, 1990).

Complicated grief. Complicated grief is described, yet criteria are absent or poorly defined (Kim & Jacobs, 1991; Condon, 1986). Prigerson et al. (1995) recognized both individual and cultural factors may increase the difficulty in determination of the level of adjustment to a loss. Lindemann (1944) termed two types of morbid grief responses: delayed and distorted. Kim and

Jacobs (1991) related that the significant difference between normal and pathological grief have to do with duration and intensity of the reaction. Horowitz, Wilner, Marmar, and Krupnick (1980) provided this definition,

> "pathological grief" is the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behavior, or remains interminably in the state of grief without progression of the mourning process toward completion. "Pathological mourning" involves processes that do not move progressively toward assimilation or accommodation but, instead, lead to stereotyped repetitions or extensive interruptions of healing. (p. 1157)

Worden (1982) identified four types of complicated grief reactions: (a) chronic grief, in which the grieving is continuing for several years and feels unfinished; (b) delayed reaction is marked by an insufficient emotional expression at the time of the loss and it resurfaces intensely at another time; (c) exaggerated reaction is indicated when the mourner is overwhelmed leading to maladaptive behavior and the person is unable to provide oneself with adequate reality testing; and (d) masked reactions may present themselves through physical symptoms, psychiatric symptoms, or acting out behavior, while the individual does not connect the symptoms with the loss.

Factors Associated with Outcome

Several factors have been related to a poor outcome of bereavement: type of relationship, past history of mental health

issues (Worden, 1982), early reaction to loss (Clayton, 1990), social variables (Worden, 1982), and type of death (Tatelbaum, 1980). Ambivalent, dependent (Horowitz et al., 1980) and narcissistic (Worden, 1982) relationships are most commonly associated with complicated bereavement. A past history of depression (Zisook & Shuchter, 1993) or any other psychiatric history including substance abuse,(Clayton, 1990) will likely influence the grief process. Poor health status prior to the loss is considered a risk factor (Clayton, 1990; Zisook & Shuchter, 1991). Severe reactions within the initial months of bereavement have been associated with continuing difficulties a year later (Clayton, 1990).

Inadequate levels of social support has been considered by many to significantly relate to a poor outcome of bereavement (Talebaum, 1980; Shuchter, 1986; Worden, 1982); however Clayton (1990) found that social support only made a difference initially, but did not influence long-term outcome. Cultural and ethnic factors may dictate behavioral norms for the bereaved (Worden, 1982) which may influence one's expression of grief (APA, 1994).

The nature and cause of death can promote a more challenging bereavement process. Raphael (1983) identified: sudden deaths, violent deaths, disasters, war, and suicide as losses associated with additional trauma. Vargas, Loya, and Hodde-Vargas (1989) research focused on significant others of those who died by accident, suicide, homicide, and unexpected death. They found

that 99% showed symptoms of depression, 64% presented preservation of the lost object, and 56% indicated signs of suicidal ideation. It is likely some losses will present multiple risk factors, increasing the possibility for complications.

## Diagnosis

The diagnostic process, at first glance, may appear rather straightforward relative to clinical guidelines. The DSM-IV (APA, 1994) used the term bereavement to describe the symptoms associated with the loss of a loved one. The U.S. Department of Health and Human Services (1993), in reference to the DSM-III-R (APA, 1987), stated that uncomplicated bereavement is "a relatively benign state that resolves spontaneously..." (p. 53). Bereavement's status in the DSM-IV is that of a V-code, indicating that it is a condition versus a mental disorder (APA, 1995). The V-Code status restricts third party reimbursement for treatment (Group for the Advancement of Psychiatry Committee on the Family, 1989). The DSM-IV (APA, 1994) stated that many symptoms of bereavement are similar to those of MDD, however the diagnosis of MDD may not be made unless these symptoms persist after two months following the death. There are presenting symptoms, however which can quicken this diagnosis: psychomotor retardation, pervasive guilt, and suicidal ideation, for these are considered atypical to bereavement (Clayton, 1990).

Clayton (1990) reported the majority of depressive symptoms are all shown early in the bereavement process and for 85% of the bereaved, their symptoms will dissipate without treatment

interventions. Clayton stated when depression does not remit, antidepressants and other treatment interventions used for depression may be utilized. She also stated expression of feelings relative to bereavement have not been found to be productive to recovery. Zisook and Shuchter (1993) reported the bereaved are at high risk of developing depression and advocate against the delay of the diagnosis of MDD. It is their opinion that this delay caused a lack of recognition, unnecessary suffering and inadequate treatment.

The usage of the diagnosis of MDD is controversial. Some clinicians and theorists have concluded grief and depression are different conditions (e.g., Osterweis, Solomon, & Green, 1984). Robinson and Fleming (1992) found differences in the cognitive patterns of those with depression and those who a present a bereavement-related depression. Conceptualizing these two groups as similar is cautioned against, in terms of diagnosis and subsequent treatment (Robinson & Fleming, 1989). Zisook and DeVaul (1983) commented that depression and unresolved grief are common outcomes to bereavement, but the relationship between these two is lacking clarification. Kim and Jacobs (1991) suggested "pathologic grief could be viewed as a conglomeration of multiple clinical syndromes" (p. 261). Horowitz (1992) encouraged the usage of a range of diagnoses indicating pathological grief is multifaceted.

Prigerson et al. (1995), in their research, reported "two distinct clusters of symptoms" (p. 26) and found complicated

grief to be a separate entity than depression. They commented however, grief reaction and depression are not mutually exclusive. Kim and Jacobs (1991) also found an overlap of symptoms, but distinctions among participants were found as well. Prigerson et al. (1995) identified common symptoms of bereavement which were not present in depression, such as, preoccupation relative to the deceased or yearning. Their work included participants who were provided the anti-depressant nortriptyline. The results suggested that the usage of this antidepressant did not affect the symptoms associated with complicated grief.

Other diagnostic possibilities, related to bereavement, are Adjustment Disorder and Anxiety Disorders. Adjustment Disorder has common features to bereavement: relative to the onset of symptoms, presentation of emotional and/or behavioral symptoms, and the existence of a psychosocial stressor (APA, 1994). This diagnosis may not be used, since the criteria for Adjustment Disorder require bereavement to be ruled out (APA, 1994). Anxiety in relation to pathological grief has been researched by Kim and Jacobs (1991). This study focused on assessing pathological grief within the framework of separation distress. Subjects whose grief was considered pathological were then assessed for depression, anxiety, and Panic Disorder. Of the participants, 83% met the criteria for Generalized Anxiety Disorder in addition to MDD, however the results did not indicate a signifcant relationship between pathological grief and anxiety.

Post-Traumatic Stress Disorder (PTSD) has been mentioned in

the literature in relation to traumatic losses. The DSM-IV (APA, 1994) description of PTSD identified the following key features: the incidence of a traumatic event, including the death of a significant other; an intense affective response; reexperiencing of the event; avoidance of stimuli promoting reminders of the event; increased arousal; numbing; and persistence of symptoms for more than one month, which cause significant distress or impairment. Prigerson et al. (1995) found under the symptoms cluster of complicated grief elements of PTSD were present. Rynerson (1984) conducted a qualitative study on a small sample of relatives of those who died by homicide. He found several symptoms associated with PTSD in the survivors. Condon (1986) studied pathological grief reactions following stillbirth. A range of diagnoses can result from this type of loss including: Dysthymic Disorder, MDD, Atypical Depression, Postpartum Psychotic Disorder, and PTSD.

Widdison & Salisbury (1990) compared PTSD of Vietnam veterans within the context of grief theory. They argued that PTSD is a grief response, and identified similarities between PTSD/Delayed Stress Syndrome and delayed grief. Goodwin (1987) commented that within combat, for purposes of survival, grief needs to be delayed; and the environmental context discourages the expression of grief. Despite the connection the above authors made between pathological grief and PTSD, only Prigerson et al. (1995) presented empirical evidence, through factor analysis, of some elements of PTSD being associated with complicated grief.

## Discussion

The distinction between complicated and uncomplicated bereavement has been shown to be unclear. The literature reported in this paper has indicated uncomplicated bereavement does not require therapeutic intervention nor is it eligible for third party reimbursement. Descriptions of complicated grief have focused on the absence or intensification of normal symptoms. The definitions presented by Worden (1982) offer a broad range of maladaptive responses to bereavement. The relationship between these definitions with existing mental health diagnoses is uncertain. It could be argued that depression and Adjustment Disorder, chronic subtype, fall under exaggerated reaction and/or a chronic reaction. As previously stated, the DSM-IV requires that Bereavement be ruled out to meet the criteria for Adjustment Disorder (APA, 1994). Depression might also fit Worden's (1982) definition of a masked reaction. Both Generalized Anxiety Disorder and PTSD may be presented in a delayed response, exaggerated, or masked reaction. The various presentations of complicated grief are being forced into the diagnostic categories of: MDD, Generalized Anxiety Disorder, and PTSD versus being considered a distinct entity, with subtypes. This appears to be the same faulty thinking of a practitioner forcing a client's presentation to fit his/her counseling theory.

Since Freud's (1957) "Mourning and Melancholia", theorists and researchers have been exploring grief and its relationship to depression. The evidence is strong that there is often an overlap

of symptoms between complicated bereavement and depression; however several researchers and theorists (e.g., Prigerson et al, 1995; Osterweis et al., 1984) caution against considering these two entities as similar. Controversy also exists relative to the treatment of bereavement-related depression. First, the research has shown that complicated bereavement often will not show the full range of depressive symptoms (Clayton, 1990). Second, there is evidence of differences in the cognitive patterns between the depressed and bereaved-depressed (Robinson & Fleming, 1992). Third, many have argued that complicated bereavement is multifaceted including the presentation of separation distress, anxiety, (e.g., Kim & Jacobs, 1991), and elements of PTSD (Prigerson et al, 1995). Last, bereavement is a response to loss (Widdison & Salisbury, 1990). Treatment needs to be guided by the etiology of complicated bereavement versus descriptive symptoms (Horowitz, 1992). While depression can be one outcome of complicated bereavement, it appears the tendency to clump these two entities together is reductionistic.

Under the current clinical guidelines symptoms of complicated bereavement are at risk of being untreated and/or mistreated. It is unclear on the reasoning behind the DSM-IV's (APA, 1994) exclusion of bereavement under the diagnosis of Adjustment Disorder. The loss of a significant other is a profound and often devastating experience. If a client is presenting symptoms of depression, this diagnosis cannot be made until two months after the loss. The individual may be delayed in

accessing services and could be treated as if the depression is unrelated to a loss. The research indicates that once depression is evident, it tends not to dissipate (Zisook & Shuchter, 1993). This raises the question, if therapeutic interventions were not delayed would the prognosis be more optimistic? Research on the presentation of anxiety disorders as an outcome of bereavement is limited. Some instances of death lend themselves to the diagnosis of PTSD. While this diagnosis does include many symptoms of complicated bereavement, the emphasis on the trauma is profound in PTSD and the range of affective, behavioral, and cognitive, responses of complicated bereavement are not adequately represented.

Future research in this area may promote a separate diagnositic category. The work of Prigerson et al. (1995) is optimistic relative to the development of a criterion-based definition of complicated bereavement. This would allow the practitioner and consumer greater consistency between the presenting issues and diagnosis. Treatment would be more accessible and lend itself to third party reimbursement. This also would allow for additional, more specific research on both the prevalence of complications relative to bereavement and treatment outcome.

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